		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041293

Facility Name: IHS CHICAGO AT GOVERNORS PARK

Address: 1420 S. BARRINGTON ROAD (Number) BARRINGTON (City) 60010 (Zip Code)

County: COOK

Telephone Number: 847-382-6664 **Fax #** 847-382-6693

IDPA ID Number: 52-167989001

Date of Initial License for Current Owners: 11/08/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: TRISH KELLY **Telephone Number:** 410-773-5681

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MELLISA WARLOW
(Title) SENIOR VICE PRESIDENT

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 150

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	75	Skilled (SNF)	75	27,375	1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,375	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,714	378	13,447	15,539	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	14,556	11,885	729	27,170	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,270	12,263	14,176	42,709	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.01%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/08/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/08/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 67 and days of care provided 9,895

Medicare Intermediary CAREFIRST OF MARYLAND

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	313,246	20,016	25,932	359,194		359,194		359,194			1
2	Food Purchase		207,228		207,228		207,228	(298)	206,930			2
3	Housekeeping	157,230	25,076	2,210	184,516		184,516		184,516			3
4	Laundry	50,734	23,687		74,421		74,421		74,421			4
5	Heat and Other Utilities			152,473	152,473		152,473	3,418	155,891			5
6	Maintenance	76,418	26,682	49,755	152,855		152,855	6,361	159,216			6
7	Other (specify):*			18,008	18,008		18,008		18,008			7
8	**TOTAL General Services**	597,628	302,689	248,378	1,148,695		1,148,695	9,481	1,158,176			8
	B. Health Care and Programs											
9	Medical Director			34,500	34,500		34,500		34,500			9
10	Nursing and Medical Records	2,968,484	470,550	367,286	3,806,320		3,806,320	37,307	3,843,627			10
10a	Therapy	795,757	70,011	19,940	885,708		885,708		885,708			10a
11	Activities	89,530	1,994	5,839	97,363		97,363		97,363			11
12	Social Services	142,663	1,757	1,920	146,340		146,340		146,340			12
13	Nurse Aide Training											13
14	Program Transportation			15,141	15,141		15,141		15,141			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,996,434	544,312	444,626	4,985,372		4,985,372	37,307	5,022,679			16
	C. General Administration											
17	Administrative	8,250		191,721	199,971		199,971	(71,527)	128,444			17
18	Directors Fees											18
19	Professional Services			102,315	102,315		102,315	54,508	156,823			19
20	Dues, Fees, Subscriptions & Promotions			106,950	106,950		106,950	(13,703)	93,247			20
21	Clerical & General Office Expenses	216,057	39,315	305,618	560,990		560,990	145,371	706,361			21
22	Employee Benefits & Payroll Taxes			694,052	694,052		694,052	390,811	1,084,863			22
23	Inservice Training & Education			5,769	5,769		5,769		5,769			23
24	Travel and Seminar			19,744	19,744		19,744	9,253	28,997			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,253	74,253		74,253	(1,132)	73,121			26
27	Other (specify):*			1,350	1,350		1,350	(1,350)				27
28	**TOTAL General Administration**	224,307	39,315	1,501,772	1,765,394		1,765,394	512,231	2,277,625			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,818,369	886,316	2,194,776	7,899,461		7,899,461	559,019	8,458,480			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK #0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,294	31,294		31,294	267,478	298,772			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(12)	(12)		(12)	15,890	15,878			32
33	Real Estate Taxes			142,441	142,441		142,441	190,622	333,063			33
34	Rent-Facility & Grounds			1,016,573	1,016,573		1,016,573	(1,016,573)				34
35	Rent-Equipment & Vehicles			211,550	211,550		211,550	3,368	214,918			35
36	Other (specify):*							173,655	173,655			36
37	**TOTAL Ownership**			1,401,846	1,401,846		1,401,846	(365,560)	1,036,286			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		376,228	121,470	497,698		497,698	(102)	497,596			39
40	Barber and Beauty Shops			6,808	6,808		6,808		6,808			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			103,081	103,081		103,081		103,081			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		376,228	231,359	607,587		607,587	(102)	607,485			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,818,369	1,262,544	3,827,981	9,908,894		9,908,894	193,357	10,102,251			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,016)	17		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(298)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	1	21		18
19	Entertainment				19
20	Contributions	(1,350)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(202,963)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE ATTACHED 5A	(349,438)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (555,064)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	748,421		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 748,421		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 193,357		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

IHS CHICAGO AT GOVERNORS PARK

ID# 0041293

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ADJUST REAL ESTATE TAX TO ACTUAL	$ 190,622	33	1
2				2
3	ADVERTISING	(19,271)	20	3
4	EMPLOYEE PATIENT LOSS FUND	(3,129)	21	4
5	HEALTH INSURANCE	310,572	22	5
6	WORKERS COMPENSATION	46,559	22	6
7	GENERAL LIABILITY INSURANCE	822	26	7
8	RENT	(1,016,573)	34	8
9	PROPERTY INSURANCE	(1,954)	26	9
10	COMMUNITY RELATIONS DEPT 515	(46,753)	21	10
11	COMMUNITY RELATIONS DEPT 530	(7,198)	20	11
12	MANAGEMENT FEES	(70,511)	17	12
13				13
14	DEPRECIATION	431,698	30	14
15	CHOW ADJUSTMENT	(164,220)	30	15
16	DENTAL VISITS	(102)	39	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(349,438)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(298)	0	0	0	0	0	0	0	0	0	0	(298)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,418	0	0	0	0	0	0	0	0	0	3,418	5
6	Maintenance	0	6,361	0	0	0	0	0	0	0	0	0	6,361	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(298)	9,779	0	0	0	0	0	0	0	0	0	9,481	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	37,307	0	0	0	0	0	0	0	0	0	37,307	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	37,307	0	0	0	0	0	0	0	0	0	37,307	16
	C. General Administration													
17	Administrative	(71,527)	0	0	0	0	0	0	0	0	0	0	(71,527)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	54,508	0	0	0	0	0	0	0	0	0	54,508	19
20	Fees, Subscriptions & Promotions	(26,469)	12,766	0	0	0	0	0	0	0	0	0	(13,703)	20
21	Clerical & General Office Expenses	(252,844)	398,215	0	0	0	0	0	0	0	0	0	145,371	21
22	Employee Benefits & Payroll Taxes	357,131	33,680	0	0	0	0	0	0	0	0	0	390,811	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	9,253	0	0	0	0	0	0	0	0	0	9,253	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,132)	0	0	0	0	0	0	0	0	0	0	(1,132)	26
27	Other (specify):*	(1,350)	0	0	0	0	0	0	0	0	0	0	(1,350)	27
28	**TOTAL General Administration**	3,809	508,422	0	0	0	0	0	0	0	0	0	512,231	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	3,511	555,508	0	0	0	0	0	0	0	0	0	559,019	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	267,478	0	0	0	0	0	0	0	0	0	0	267,478	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	15,890	0	0	0	0	0	0	0	0	0	15,890	32
33	Real Estate Taxes	190,622	0	0	0	0	0	0	0	0	0	0	190,622	33
34	Rent-Facility & Grounds	(1,016,573)	0	0	0	0	0	0	0	0	0	0	(1,016,573)	34
35	Rent-Equipment & Vehicles	0	3,368	0	0	0	0	0	0	0	0	0	3,368	35
36	Other (specify):*	0	173,655	0	0	0	0	0	0	0	0	0	173,655	36
37	**TOTAL Ownership**	(558,473)	192,913	0	0	0	0	0	0	0	0	0	(365,560)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(102)	0	0	0	0	0	0	0	0	0	0	(102)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(102)	0	0	0	0	0	0	0	0	0	0	(102)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(555,064)	748,421	0	0	0	0	0	0	0	0	0	193,357	45

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
TRN HEALTHCARE INC	50	EXCEPTIONAL CARE				
LYRIC - IHS	40	EXCEPTIONAL CARE	BURBANK	INTEGRATED HEAL	BALTIMORE	HOME OFFICE
PHARMERICA	10	EXCEPTIONAL CARE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	HEAT & OTHER UTILITIES	$	LYRIC - IHS	40.00%	$ 3,418	$ 3,418	1
2	V	6	REPAIRS & MAINTENANCE		LYRIC - IHS	40.00%	6,361	6,361	2
3	V	10	CLINICAL		LYRIC - IHS	40.00%	37,307	37,307	3
4	V	19	PROFESSIONAL SERVICE		LYRIC - IHS	40.00%	54,508	54,508	4
5	V	20	DUES, FEES & SUBSCRIPTIONS		LYRIC - IHS	40.00%	12,766	12,766	5
6	V	21	CLERICAL & GENERAL		LYRIC - IHS	40.00%	398,215	398,215	6
7	V	22	EMPLOYEE BENEFITS		LYRIC - IHS	40.00%	33,680	33,680	7
8	V	24	TRANSPORTATION		LYRIC - IHS	40.00%	9,253	9,253	8
9	V	35	RENT - EQUIPMENT & VEHICLES		LYRIC - IHS	40.00%	3,368	3,368	9
10	V	36	OTHER HOME OFFICE CAPITAL		LYRIC - IHS	40.00%	173,655	173,655	10
11	V	32	INTEREST		LYRIC - IHS	40.00%	15,890	15,890	11
12	V								12
13	V								13
14	Total			$			$ 748,421	$ * 748,421	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTEGRATED HEALTH SERVICES, INC
Street Address: 910 RIDGEBROOK ROAD, BLDG 300
City / State / Zip Code: SPARKS, MD 21152
Phone Number: (410-773-5681
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DIRECT TRACKING OF EXPENSES AND ALLOCATION OF POOLED COSTS BASED ON				$	$		$	1
2		PERCENT OF TOTAL COSTS								2
3										3
4		SEE HOME OFFICE COST REPORT								4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	404,546	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	333,063	2
3. Under or (over) accrual (line 2 minus line 1).	$	(71,483)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	3,330,634	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	3,259,151	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	293,015	8
	1998	378,641	9
	1999	398,499	10
	2000	409,571	11
	2001	404,546	12

2001 ACTUAL TAX

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME IHS CHICAGO AT GOVERNORS PARK COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0041293

CONTACT PERSON REGARDING THIS REPORT TRISH KELLY

TELEPHONE 410-773-5681 FAX #: 410-773-5829

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-12-107-016-0000	LONG TERM CARE FACILITY	$ 333,062.86	$ 333,062.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 333,062.86	$ 333,062.86

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 34,765 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	34,765	1995	$ 1,880,404	1
2					2
3	TOTALS	34,765		$ 1,880,404	3

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1995	1985	$ 7,322,291	$ 366,115	20	$ 366,115	$	$ 2,593,311	4
5			1995	1985	3,080	77	40	77		520	5
6			1995	1985	145,242	3,631	40	3,631		23,904	6
7											7
8											8
	Improvement Type**										
9	FLOORING			1997	2,000	100	20	100		600	9
10	UPGRADES/TILING/DOORS FOR VENTILATOR CAPABILITY			1997	32,786	1,639	20	1,639		9,834	10
11	PAINTING/ELECTRICAL			1997	3,899	260	15	260		1,560	11
12	FIRE SYSTEM REPAIR			1997	13,237	882	15	882		5,000	12
13	EMERGENCY CIRCUITS			1997	7,684	384	20	384		2,081	13
14	EMERGENCY CIRCUITS			1997	2,847	142	20	142		771	14
15	PAVEMENT RENOVATION			1997	1,141	114	10	114		589	15
16	ARCHITECTURAL DRAWINGS			1997	300	15	20	15		90	16
17	A/C COMPRESSOR			1997	3,153	158	20	158		948	17
18	AIR HANDLING WORK			1997	1,825	91	20	91		546	18
19	MERCURY SWITCH			1997	626	31	20	31		186	19
20	NURSE CALL SYSTEM			1997	628	31	20	31		186	20
21	FIRE SYSTEM			1997	640	32	20	32		192	21
22	PAINTING/ELECTRICAL			1997	4,150	208	20	208		1,248	22
23	ARCHITECTURAL			1997	300	15	20	15		90	23
24	WATER HEATER REPAIR			1998	3,200	320	10	320		1,467	24
25	NEW CONCRETE/LANDSCAPING FOR EROSION PREVENTION			1998	14,905	745	20	745		3,105	25
26	UPGRADE ROOM TO SUITE			1998	1,100	55	20	55		275	26
27	B WING PAINTING			1998	8,100	540	15	540		2,250	27
28	WASHER PLUS INSTALLATION			1998	15,664	1,044	15	1,044		4,351	28
29	DRIVEWAY REPAIRS			1999	4,450	556	8	556		1,715	29
30	FIRE SYSTEM ACCELERATOR			1999	4,700	470	10	470		1,449	30
31	FIRE SYSTEM REPAIR			1999	1,608	161	10	161		644	31
32	FLOORING			2000	2,343	234	10	234		585	32
33	REAR PARKING LOT REPAIR			2000	3,635	121	10	121		363	33
34	REPAIR SPRINKLER SYSTEM			2001	5,309	212	25	212		424	34
35	SECURITY SYSTEM			2001	1,199	240	5	240		380	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PIPE REPAIR	2001	$ 5,121	$ 102	25	$ 102	$	$ 204	37
38	AIR CONDITIONER REPAIR	2001	9,562	478	10	478		956	38
39	CEILING REPAIR	2001	4,131	172	12	172		344	39
40	SMOKE DETECTOR TEST	2001	822	69	5	69		138	40
41	PUMPS FOR BOILER	2001	2,680	112	10	112		224	41
42	REPLACE SCREEN & FRAME	2001	4,502	188	10	188		376	42
43	REPAIR BACK PARKING LOT	2001	3,635	485	10	485		970	43
44	HEAT EXCHANGER	2001	3,327	111	10	111		222	44
45	PAVE/RESURFACE PARKING LOT	2001	27,890	581	8	581		1,162	45
46	CARPETING	2001	61,658	1,028	5	1,028		2,056	46
47	WALL REPAIRS	2002	6,170	566	10	566		566	47
48	PLUMBING INSTALLATION	2002	5,530	161	20	161		161	48
49	TILE FLOOR REPAIRS	2002	1,050	13	20	13		13	49
50	EXTERIOR WALL REPAIRS	2002	939	31	10	31		31	50
51	GARBAGE DISPOSAL REPLACEMENT	2002	3,495	408	5	408		408	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,752,554	$ 383,128		$ 383,128	$	$ 2,666,495	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 635,942	$ 78,288	$ 78,288	$	10	$ 453,031	71
72	Current Year Purchases	20,424	1,576	1,576		10	1,576	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 656,366	$ 79,864	$ 79,864	$		$ 454,607	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,289,324	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 462,992	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 462,992	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,121,102	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.		$
13.		$
14.		$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 211,550 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a 1	7542 hrs	$ 187,331	379	$ 5,789	$	7,921	$ 193,120	1
2	Licensed Speech and Language Development Therapist	10a 1	2033 hrs	47,258	23	225		2,056	47,483	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a 1	12801 hrs	257,241	296	4,523		13,097	261,764	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10-2 / 39-2	# of prescrpts				563,525		563,525	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RT (col. 1) X-Ray/Lab	39-3 / 40-3				117,743			117,743	13
14	TOTAL			$ 491,830	698	$ 128,280	$ 563,525	23,074	$ 1,183,635	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 325,932	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,264,059		3
4	Supply Inventory (priced at)	167,145		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	(84,859)		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,672,277	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,903,729		13
14	Buildings, at Historical Cost	7,661,120		14
15	Leasehold Improvements, at Historical Cost	7,130		15
16	Equipment, at Historical Cost	717,345		16
17	Accumulated Depreciation (book methods)	(2,689,286)		17
18	Deferred Charges	6,797		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): INTERCOMPANY TRANSFER	(2,488,460)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,118,375	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,790,652	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 152,236	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	214,761		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,214		31
32	Accrued Real Estate Taxes(Sch.IX-B)	327,754		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(2,637)		35
	Other Current Liabilities(specify):			
36	401K W/H	7,980		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 708,308	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	INTERCOMPANY TRANSFERS	9,643,418		43
44	ROUNDING	2		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,643,420	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,351,728	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,561,076)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,790,652	$	48

***(See instructions.)**

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,243,989)	1
2	Restatements (describe):		2
3	PRIOR YEAR AUDIT ADJUSTMENT	(653,971)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,897,960)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(663,116)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (663,116)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,561,076)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,040,224	1
2	Discounts and Allowances for all Levels	(8,405,268)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,634,956	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,664,230	6
7	Oxygen	14,400	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,678,630	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	823,666	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	74,501	19
20	Radiology and X-Ray	24,370	20
21	Other Medical Services	7,955	21
22	Laundry	688	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 931,180	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	INTEREST INCOME	1,016	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,016	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,245,782	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,148,695	31
32	Health Care	4,985,372	32
33	General Administration	1,765,394	33
	B. Capital Expense		
34	Ownership	1,401,846	34
	C. Ancillary Expense		
35	Special Cost Centers	504,506	35
36	Provider Participation Fee	103,081	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,908,894	40
41	**Income before Income Taxes (line 30 minus line 40)****	(663,112)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (663,112)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	344	344	$ 10,251	$ 29.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	48,354	51,081	1,281,146	25.08	3
4	Licensed Practical Nurses	19,667	20,724	437,974	21.13	4
5	Nurse Aides & Orderlies	82,670	87,113	1,188,639	13.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	20,749	22,214	473,689	21.32	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,466	7,046	89,530	12.71	10
11	Social Service Workers	6,880	7,517	142,663	18.98	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	25,090	27,311	313,246	11.47	15
16	Dishwashers					16
17	Maintenance Workers	3,931	4,219	76,418	18.11	17
18	Housekeepers	17,412	18,326	157,230	8.58	18
19	Laundry	5,356	5,893	50,734	8.61	19
20	Administrator	256	264	8,250	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,333	13,617	216,057	15.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,146	1,193	12,440	10.43	31
32	Other Health C: RT	14,318	15,117	333,314	22.05	32
33	Other(specify) CENTRAL SUPPI	2,323	2,453	26,788	10.92	33
34	TOTAL (lines 1 - 33)	267,295	284,432	$ 4,818,369 *	$ 16.94	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 25,932	1-3	35
36	Medical Director	MONTHLY	28,860	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	AS NEEDED	1,798	10.1-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 56,590		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,238	$ 154,646	10-3	50
51	Licensed Practical Nurses	1,012	79,347	10-3	51
52	Nurse Aides	2,640	68,423	10-3	52
53	TOTAL (lines 50 - 52)	6,890	$ 302,416		53

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RICHARD RIMKUS	ADMINISTRATOR	0	$ 8,250
(note - administrator is contracted position)			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 8,250

B. Administrative - Other

Description	Amount
LYRIC MANAGEMENT FEE	$ 191,721
TOTAL (agree to Schedule V, line 17, col. 3)	$ 191,721
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Admin Wages	CPS	$ 56,768
Baird Melnick Ass	CPS	1,867
Frontrunner Network	CPS	4,216
Marvin F Poer & Co	CPS	11,621
Prairie Baskets	CPS	1,993
McCormick & Wagner	CPS	3,000
Signature Painting	CPS	7,950
KPMG	Accounting	7,274
Vinick & Docherty	Accounting	2,780
Medi.Com	Software	3,579
Paige Personnel Services	CPS	1,267
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 102,315

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 137,281
Unemployment Compensation Insurance	22,390
FICA Taxes	358,523
Employee Health Insurance	517,564
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	4,298
HOME OFFICE COSTS	33,218
ALLOCATED BENEFITS	11,127
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,084,401

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 25,662
Advertising: Employee Recruitment	66,580
Health Care Worker Background Check	5,480
(Indicate # of checks performed)	
DUES & SUBSCRITPTIONS	9,228
HOME OFFICE	12,766
Less: Public Relations Expense	(7,198)
Non-allowable advertising	(19,271)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 93,247

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SEE ATTACHED SCHEDULE	19,744
HOME OFFICE	9,253
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,997

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK **#** 0041293 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **121,332** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **103,081**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.